March 2015

In Touch

In this issue.....

Key Contract Changes 2015/16

Liz Mears

Listed below is a summary of the key changes to the National Contract for 2015/16:-

Named GP for all patients

The named GP requirement will be extended to all patients. By 31 March 2016 all practices will need to include on their website reference to the fact that all patients (including children) have been allocated a named, accountable GP (Partner or Salaried).

Patients' online access to medical records

Patient online access to their medical record will be widened in 2015/16, but with some flexibility for practices in how this is implemented.

Practices will also be required to offer online access to all detailed information, where requested by a patient, i.e. information that is held in a coded form within the patient's medical record. GP software will be configured to offer all coded data by default but GPs will have the option and configuration tools to withhold coded information where they judge it to be in the patient's interests or where there is reference to a third party.

Online appointment booking

To expand the number of appointments booked online and to ensure that there is appropriate availability of appointments for online booking.

Assurance of Out of Hours provision

Practices to provide information to allow the CCG to assure itself that the delivery of out of hours care is in line with the National Quality Requirements.

QOF

No change to the size of QOF or thresholds. The value of a QOF point will be adjusted in 2015/16 taking account of population growth and relative changes in practice list size for one year from 1 January 2014.

Armed forces

The GMS Regulations will be amended to allow for armed forces personnel within a specified cohort to be registered with a GP practice for longer than three months and up to a maximum of two years.

Maternity and paternity cover

Payments to cover maternity, paternity and adoption leave will no longer be discretionary and all practices will be entitled to reimbursement which will cover both external locums and cover provided by existing GPs within the practice who do not already work full time.

Avoiding Unplanned Admissions

The service will be extended for a further year with changes including revisions to simplify the reporting process and changes to the payments structure.

Patient participation

This will cease on 31 March 2015 and the associated funding will be reinvested in global sum with no out of hours

deduction being applied.
From 1 April 2015, it will be a contractual requirement for all practices to have a PPG and to make reasonable efforts for this to be representative of the practice population. This is expected for CQC inspection.

Alcohol enhanced service
This will cease on 31 March 2015 and the associated funding will be reinvested in global sum with no out of hours deduction being applied.

From 1 April 2015 it will be a contractual requirement for all practices to identify and code newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels.

Publication of GP earnings
It will be a contractual requirement for practices to publish on their practice websites by 31 March 2016 mean net earnings that relate to the GMS contract for GPs in their practice (contractor and salaried GPs) relating to 2014/15 alongside the number of full and part time GPs associated with the published figure.

Seniority
As part of the 2014/15 GMS contract agreement seniority payments will cease on 31 March 2020 and that there would be a 15% reduction in seniority payments year on year with no new entrants to the scheme.

Pre-Employment Checks for Locum GPs

Carlo Caruso

I'm sure some of you are aware of the recent story about a woman who pretended to be a GP and managed to work a number of sessions across England, including the South East. We are not entirely sure of the circumstances behind this except that she had used the name and GMC number of a GP on the register. We are also aware that there have been instances in which locums engaged by practices via locum agencies were not registered on the National Performers List. As a result we felt it might be beneficial to revisit what practices are required to do when engaging locums.

The CQC Key Lines of Enquiry ("KLOE") and the GP Contract require practices to ensure that all staff have the "right qualifications, skills, knowledge and experience to do their job".

The GP Contract elaborates upon these requirements with practices having to ensure that any new GPs are registered with both the GMC and the National Performers List. Practices need to also be aware of what, if any, restrictions have been placed on a locum's registrations. If there are any restrictions then practices will be required to ensure that the locum complies with the conditions in so far as they are relevant to the delivery of the contract.

In addition to checking a locum's registrations practices will need to obtain two references relating to two recent posts, which may include any current posts, lasting at least three months without a significant break. Where this is not possible practices are required to obtain a full explanation and alternative referees from the locum.

If practices employ the same locum GP within 3 months of their previous employment they can rely on the references previously obtained.

There is, however, some divergence about when the checks need to be in place. The CQC Provider Handbook states that these checks need to be in place, "when [the locum] starts their employment". However, the contract provides that, if the medical practitioner is urgently needed, practices can carry out the registration and reference checks after the locum has started work.

Locums can be employed or engaged for a single period of up to 7 days whilst practices check their registration or, in the case of references, for a single period of up to 14 days while these are checked and considered. Practices may also engage them for another single period of 7 days, in addition to the initial 14 days, if they believe the person supplying the reference is temporarily unavailable.

Whether practices need to check the identity can arguably depend on whether they will be employed directly or sub-contracted via a locum agency. Nevertheless, we advise that, despite any assurances practices receive from the locum agency about the authenticity of the individual, the responsibility for this, and the other checks mentioned, remain with practices.

*** Hot off the Press ***

Please see below the BMA Focus On document outlining the main changes in GP contract payments this year.

FOCUS ON GP CONTRACT PAYMENTS 2015/16

Payments to GP contractors will change from 1 April 2015 to reflect negotiated contract changes and the Government's acceptance of the Doctors and Dentists Review Body recommendation for contractor GPs.

2015/16 Doctors and Dentists Review Body (DDRB) recommendation
The DDRB recommended that GPs should receive a 1 per cent increase in pay in 2015/16. This recommendation was made in respect of net income. The Government has used a formula previously employed by the DDRB to calculate the gross uplift to GP contracts it believes is necessary to achieve this net outcome. On the basis of this calculation, the overall value of the GMS contract will be increased by 1.16 per cent. All of this increase will be applied through global sum payments. PMS and APMS practices will receive equivalent increases.

2015/16 increase to global sum
On 1 April 2015, the global sum price per weighted patient will increase from £73.56 (2014/15) to **£75.77 –** an increase of 3 per cent.
This increase is a result of:

- the phasing out of the Minimum Practice Income Guarantee (MPIG) and reinvestment of a further 1/7th of the value of correction factor funding into global sum
- changes to enhanced services and subsequent reinvestment into global sum (the patient participation scheme and alcohol risk reduction scheme have ended)
- a gross uplift to contract payments of 1.16 per cent following implementation of the DDRB's recommendation (see above). As all of this total uplift is applied through the global sum, global sum payments will increase by 1.7% for this reason alone.

For this year only, there will be a further increase in the GMS global sum price per weighted patient on 1 October to reflect changes to the seniority scheme and reinvestment of this funding.

QOF points
The pound per point value of QOF will increase from £156.92 (2014/15) to **£160.15** in 2015/16. This reflects population growth and relative changes in practice list size.

Out of hours 'opt out' deduction
The out of hours (OOH) 'opt out' deduction will not apply to the reinvestment of MPIG, enhanced services and seniority funds. As a result, the percentage value of the OOH deduction for opted out GMS practices will reduce from 5.46 per cent (2014/15) to **5.39 per cent** in the first half of 2015/16**.**

Like global sum, for this year only, the OOH deduction will change again on 1 October 2015 to reflect seniority changes.

Uplifts for PMS and APMS practices
NHS England has published guidance for Area Teams and CCGs instructing them to take a consistent and equitable approach to uplifts for PMS and APMS practices. PMS and APMS practices will receive increases equivalent to the GMS increases for those changes that impact on their contracts.

The following table is taken from the NHS England guidance for commissioners.
GMS, PMS and APMS £/weighted patient increases to core funding 2015/16

	GMS	PMS	APMS
MPIG reinvestment	£0.55	-	-
ES reinvestment	£0.41	£0.41	£0.41
Inflation uplift	£1.25	£1.25	£1.25
Total uplift	**£2.21**	**£1.66**	**£1.66**

Quality First: Managing Workload to deliver safe patient care—*Liz Mears*

In January 2015 the BMA published this very welcomed document. The guidance is not about restricting GP services, "it is about providing safe, quality and accessible care to patients, at a time when GPs are being prevented from doing so by excessive and inappropriate or unresourced work, which is taking them away from their prime duty of care as GPs".

The guidance covers:

- Reducing clinical workload that is inappropriate
- Reviewing and limiting voluntary additional work
- Measures to cease unfunded or under resourced work
- Working in partnership with patients
- Working in collaboration with neighbouring practices to manage workload
- Developing new systems of working
- Measures to manage list size (see John Allingham's article)
- Guiding GPs to seek assistance if impacting on contractual, professional duty of care or their own health.

We would urge you to read this document and discuss at a partnership meeting to look at what aspects may be of help to manage your workloads. David Barr has taken the templates from this document and created LMC Advice Sheets that you are welcome to use (which are available on our website: www.kentlmc.org under advice & information/managing workload).

List Management

Dr John Allingham

Many practices are struggling to cope with the escalating workload demands and are constrained by premises and or difficulty recruiting. One way of easing the workload is to manage the number of patients on the practice's registered list using the regulations carefully.

Formal List Closure:
Application to formally close the list involves an assessment process and results in closure for a period of time up to a maximum of 12 months. This requires the approval of NHS England which is not necessarily granted.

Informal List Closure:
Many practices are now managing their lists by using paragraph 171 of the General Medical Services Contract which states 'The Contractor MAY accept an application for inclusion in its list'. Note the word MAY not MUST!

The regulations continue to state an application to join the list 'shall only be refused if the contractor has reasonable grounds that do not relate to race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.' Within 14 days the practice must notify an applicant in writing of the refusal to accept an application to join the list and the reasons for this.

A lack of capacity is a 'reasonable ground' and a practice can produce a standard letter for reception staff to provide to applicants.

Practices must keep a written record of such refusals and be prepared to make it available to NHS England on request. A computer log or record book accessible to reception staff and updated as each applicant is declined should be maintained.

Practical Considerations in operating an 'informal list closure'

- Staff need to understand exactly what is required and not deviate from the rules. No exceptions.
- The simplest way to be non-discriminatory is to decline all applications to join the list.
- The only exceptions might be newborn babies or applicants who join an existing household eg returning students, new partners.
- The decision to operate an informal list closure should be recorded in the minutes of a practice meeting and reviewed on a regular basis possibly monthly.
- The letter to the patients should be honest and include statements to reflect that the decision remains under review and may be reversed if the situation changes. It must be reasonable, transparent and justifiable.
- Practices should have a written policy that all relevant staff have read and ideally signed.

Some practices maintain their lists at a level by taking on the same number of patients a month as left the list the previous month. This is within the regulations as outlined here.

In January 2015 the BMA published 'Quality First: Managing workload to deliver safe patient care'. This is available on the BMA website and includes other advice such as reducing the size of a practice area.

The LMC can be contacted for advice or clarification.

Health Warning – Sale & Leaseback Transactions

Rosemary Jones, Invicta Chartered Surveyors

There has been a flurry of activity recently amongst investors seeking to purchase GP surgeries owned by the Partners and to lease the premises back to the practice.

The continuing low interest rates offered by traditional savings means that the comparable interest rate (or "yield" as it is known) makes investment in GP surgeries highly attractive. Compared to other property sectors, the security of the rental income stream from GP Tenants is perceived as relatively secure, being backed by central Government via the rent reimbursement system. GP Surgeries are therefore seen as low risk and even smaller premises are proving attractive to private investors who hitherto might not have risked investing in property.

From the property owning partners' viewpoint, there is the attraction of releasing equity in the property before retirement which may attract lower rates of Capital Gains Tax. Also, leased premises can make recruitment of new Partners easier because the need to raise finance to buy into the Partnership disappears.
However, GPs need to be aware of the requirement to achieve NHS England approval to the transaction and, in particular, the lease terms, ***prior*** to signing any contract for sale of the property and its lease back. NHSE can refuse to support the transaction financially (i.e. decline an application to reimburse the lease rent, VAT on rent and business rates) if their approval is not secured beforehand. This could leave the Tenant GPs with an obligation to pay rent to their Landlord but no reimbursement.

Partners should also be wary of accepting any single offer made to sell, however attractive it might be. Recent experience has shown that a private approach by an investor was improved by almost 50% when the surgery was offered off-market but to a wider number of potential buyers.

From experience, NHS England locally are seeking to limit exposure to increased recurrent funding. This can narrow down potential buyers to those who agree not to charge VAT on rent. Depending on the age of the building, NHSE may not support a long lease. Both factors have a depreciating effect on sale price.

Seek professional advice on any approaches from a healthcare specialist Chartered Surveyor at the earliest opportunity.

Rosemary Jones
Invicta Chartered Surveyors
www.invictasurveyors.com

Adolescent death in Kent Caused by Acute Asthma

Andrew Scott-Clark, Chair, KSCB Child Death Overview Panel

A recent adolescent death in Kent was caused by acute asthma, and the attention of the Kent Child Death Overview Panel was drawn to the National Review of Asthma Deaths (NRAD) Confidential Enquiry published in May 2014, which highlighted issues of asthma care.

Link to the full report is as follows:
http://www.asthma.org.uk/nrad-report

The Panel would like to draw the report to the attention of GPs and primary care staff in Kent and in particular the findings around medication use where the Enquiry found evidence of:

- Excessive prescribing of 'reliever' medication
- Evidence of under-prescribing of 'preventer' medication

The report goes on to make a number of recommendations, and in particular around prescribing and medication use:

"all asthma patients who have been prescribed more than 12 'short' acting reliever inhalers in the previous 12 months should be invited for urgent review of their asthma control, with the aim of improving their asthma through education and change of treatment if required".

The Child Death Overview Panel would particularly like to highlight these recommendations in relation to adolescents who are often poor at adhering to chronic illness medication regimens.

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David Barr's Retirement

A Letter to the Editor...

Dear Colleagues

The times they are still changing and after 17 years, I have at long last decided to retire from the LMC at the end of this July. I have during this time been involved in many challenging developments as the LMC has evolved into the organisation it is today, but the time has come to take on new exciting tasks, particularly my little granddaughter, with a second grandchild due in August.

The following is a reflection on the LMC since I joined the organisation as the Clerk on 1 September 1998 following a 9 year stint at the BMA as the Industrial Relations Officer for Kent.

Times were certainly changing then, as now. General Practice in Kent at that time was managed by two Health Authorities, the Red Book was still alive, but very much on its last legs. Frank Dobson as Secretary of State for Health led the reforms, which included the birth of Primary Care Groups and the belief by many that GPs would at last be at the forefront of the modernisation of the NHS, following years of Conservative market forces ruling the health service. These were initially, heady days and was the impetus for the LMC to rapidly develop its organisation to mirror the new structures in the NHS.

Dr John Ashton (the Medical Secretary) and I set about reorganising the LMC into constituencies that mirrored the 9 PCGs. We sought formal recognition agreements with each PCG and brought the elected LMC members directly into negotiations and consultations with the PCG Boards.

Whilst structures were changing, work had already begun on what was to become the 2004 New GMS Contract. The LMC arranged mass meetings of GPs across Kent to explain the radical reforms under consideration and to prepare practices for the new systems required to take full advantage of the contract. Kent was well placed to take advantage of the new opportunities, particularly in East Kent with the PRICCE scheme, and practices certainly did.

At the same time, the LMC office was still dealing with the majority of its communications and transactions on paper based systems. The only two computers were used exclusively as word processors. I led the office development of a dedicated IT system which was subsequently adopted by several other LMCs. The system provided the transition from paper to electronic communications. It provided the LMC with a database of GPs and practices in Kent that afforded a knowledge base, which still serves the LMC well in its negotiations with the NHS and CCGs. The LMC website provided the means for regularly updating practices and remains a resource still well used by practices and NHS staff today.

Kent LMC was the first LMC to recognise the need to focus its organisation on what rapidly became the PCTs, to involve LMC members directly in negotiations with the PCT Chief Officers and to seek to hold them to account. All GPs were kept informed by the regular newsletters that went out following negotiations. The structures set up in those early days still form the foundation of the LMC organisation today.

The work of the LMC grew rapidly from 2004, particularly as the PCTs gained new powers to deal with the performance of both practices and individual GPs. Supporting individual GPs and practices became a substantial part of LMC work. To cope with the work, Di Tyas was recruited and the LMC increased the sessions of the Medical Secretaries.

Kent LMC is one of the few LMCs that continues to run a full education programme for practice staff and developed a standalone Employment Law Helpline, which continues to provide significant HR

support to practices. None of this however would have been achieved without the forward looking LMC representatives that have been elected by the members to serve Kent. All of them, particularly the LMC Chairmen and Vice Chairmen, have provided unstinting support to myself and all my colleagues at the office for which I am extremely grateful. It has allowed the LMC to develop new ideas and new ways of working in an open and collaborative way. Anyone who has visited the office will know that we work in an open plan space (bought by the LMC 9 years ago), with gratefully little bureaucracy and with an inclusive culture. I very much believe this has served the LMC well.

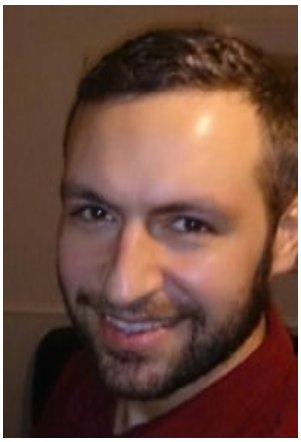
I do not doubt that I will be leaving an LMC fit for purpose and fit for the future. You have experienced Medical Secretaries, dedicated office management professionals and with the more recent appointment of the new Clerk and Deputy Clerk who have the skills and ability to continue to build the Kent LMC.

I would like to thank all the GPs, Practice Managers, Practice Staff, the many NHS staff and other professionals I have worked with for their expertise, courtesy, generosity and pleasure that have made my 17 years at the LMC so rewarding.

Wishing you all well for the future of the NHS.
Yours sincerely
David

Welcome to Carlo Caruso…

Liz Mears



The LMC are very pleased to welcome Carlo Caruso as Deputy Clerk.

Carlo was recruited from a strong field of applicants and joined us in January 2015. He worked for the NHS for the last 7 years in Kent and Medway and has brought a great set of skills with him to the LMC.

We asked Carlo to provide some interesting background information about himself to share.

I was born in Cham, Switzerland. Cham is situated in the Canton of Zug. Whilst living there I recall speaking German at play school, Italian to my dad and English with my mum. We moved to England when I was about 8 years old and because I grew up in a bi-lingual household I managed to keep up my knowledge of Italian. However, aside from being able to order a bratwurst or ask for directions to the local train station in German, I may not be able to fully understand the reply if it exceeds 2 sentences!

I started my working life at Canterbury City Council supporting elected representatives in providing an overview of decisions made by the Executive and scrutiny reviews of services provided in the district by either the City or County Council. I followed this with 7 years at East Kent PCT and then the Area Team, mainly dealing with doctors in difficulty.

Activities that occupy my spare time include playing the guitar and ukulele, and learning Spanish. I acquired an electric piano in January this year and have set myself a target of being able to play a tune competently by the end of the year, so listen out for horrendous, ear bleeding renditions of three blind mice from the LMC office.

I also enjoy travelling and have visited many places including Bali, Morocco, Croatia, Mexico and Peru to name a few. I have family in Italy which takes me back there on a yearly basis, and if ever I miss them too much I can always look up my grandparents on Google Street Map pictures of rural Italy!

Update from the GP Staff Training Team

Sue Timmins, Senior Associate L&D, GP Staff Training SECSU

The training team continues to be busy as the end of the financial year approaches. The number of episodes of training delivered this year is likely to be comparable to last year, which is commendable.

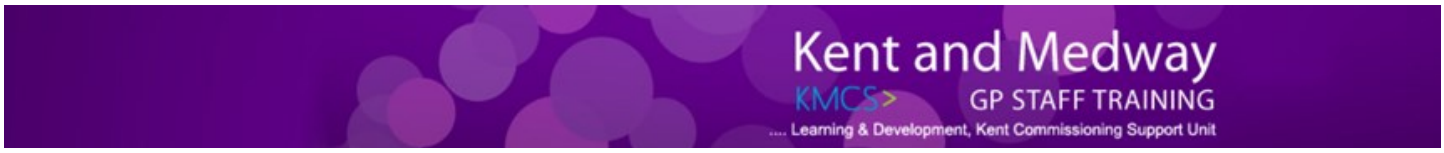
All practices contribute to the training top-slice on the basis of their patient list size, for the training of their non-medical personnel in topics which support core GP services; we remind you that the central training budget cannot be used for training in connection with Enhanced or Specialist services. We continue to work closely with the CCG Primary Care leads in respect of the funding from Health Education Kent, Surrey and Sussex which has now transferred to their management.

We are currently in the process of appointing new trainers for the 2015-16 training programme, which this year involves the support of the procurements team in conducting the bidding process for the topics which we need to deliver. This is well in hand and we will begin to offer the new programme as soon as the trainers are appointed. Certain topics offered by external trainers, e.g. Imms and Vaccs, are already available to book via Learning Pool. Other topics such as the KASPAC course, and cervical screening, are being prioritised, and will be offered to people on the waiting list before we open them up for general registration.

In the meantime, we wish to remind practices that, whilst we are receptive to considering reimbursement or direct funding for places on external courses where appropriate (particularly at those times when a core topic is not currently available through our programme), it is essential that funding approval to do this is sought in advance of making any such arrangements. We cannot guarantee to reimburse or fund any training episode for which advance approval and appropriate invoicing arrangements have not been given by the KMGP team before arrangements are made by practices with training providers.

Likewise, we are aware that some practices have approached our currently-contracted trainers direct for repeat in-house training, e.g. Life Support; this arises when a trainer has been before to that practice and they would like them to return the next year. Our difficulty with this is two-fold: firstly, under their contract with us, the instructions for training must only come from the KMGP team, otherwise we cannot guarantee payment, and secondly, where the training is in a different financial year, that trainer may not be in contract with us in the new year (it is all dependent on the outcomes of the procurement process), so we might not be able to use them anyway. Please contact us in the first instance about your in-house training requirements – we are happy to note that you would like a particular training company if they are still available to us in the new financial year.

The team thank you all for your continued support over a difficult period in past months. If you have any queries, please direct them to our central email account kmgpstafftraining@nhs.net in the first instance.



NHS Pension Change—Again!

Paul Gordon – MacArthur Gordon Limited

The NHS Pension is changing from the beginning of April 2015. If you had more than 10 years until your Normal Retirement Age as of the 1st April 2012 you are going to have two NHS Pensions.

Your existing benefits within the 1995 or 2008 sections of the Scheme will be protected and will continue to increase until being drawn at retirement (or 24 Hour Retirement).

The 2015 Scheme is different. The retirement age will be linked to your State Retirement Age, the benefits will be calculated on a Career Average Revalued Earnings basis with 1/54th of your Superannuable Income accrued as a pension, for example, if you were to earn £54,000 your pension benefits would be £1,000 a year of pension. The pension earned during 2015/2016 will be increased by Consumer Price Index plus 1.5% with every year of membership so is likely to be significant by retirement.

It is going to be possible to access pension benefits in two stages, with benefits accrued within the 1995 or 2008 Sections accessible at 60 or 65 respectively without reduction. It could provide the ability to reduce sessions but maintain a similar level of income ahead of full retirement at a later age.

There continues to be both death

in service and ill-health benefits provided by the NHS Pension although they do worsen if you were to opt out of the Scheme. It is now more important than ever to ensure you and the practice have a medical specialist accountant particularly in light of the recent reduction to the Annual Allowance and Lifetime Allowance.

I would suggest everyone reviews their NHS Pension benefits annually and contacts the Pensions Agency to request the following information:

- Membership Statement
- Dynamisation Sheet
- Most recent Annual Allowance Statement
- Estimate of Accrued Benefits*

*If you are planning on retirement before May 2016 you may need to request an estimate of benefits as at the 5th April 2014 for the purposes of Individual Protection 2014 as you are still only permitted to receive one free estimate a year.

If you currently have Enhanced Protection it is essential to understand joining the 2015 Section of the Scheme will lead to the protection being lost and HMRC must be informed.

The following link is the NHS Pensions Agency Factsheet:

http://www.nhsbsa.nhs.uk/Documents/Pensions/Loss_of_Enhanced_Protection_and_Fixed_Protection_2012_and_2014_because_of_the_2015_NHS_Pension_Scheme_03.03.2014_(v2).pdf

It is important to realise that the NHS Pension remains a government backed, guaranteed pension which provides an index-linked pension for life, along with ill-health benefits and death benefits to your spouse and family in the event of your demise. Any decisions around the NHS Pension should not be taken lightly and must be made with your financial circumstances and planning in mind.

Paul Gordon
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DBS Checks

Carlo Caruso

Disclosure & Barring Service

As part of the procurement process for the single national Primary Care Support Services ("PCSS") contract, NHS England has led a review of the bundle of back office functions provided by the Kent Primary Care Agency, the local PCSS organisation, for General Practice. Services are being categorised as being either "in scope", which means they will continue to be provided, or "out of scope", which will no longer be provided, from the 1st April 2015.

One service that will be 'out of scope' is the Disclosure and Barring Service checks. This will affect General Practice in 3 ways:

1. CQC registration;
2. pre-employment checks; and
3. applications for inclusion on the National Performers List.

CQC Registration

During the first wave of registrations the CQC accepted, in lieu of a CQC countersigned DBS Enhanced Disclosure Certificate, the GMC numbers of registered GP providers along with a declaration that they have had a DBS certificate with a PCT and had not been convicted or charged with any actual or alleged offences since then.

If you have not had to make changes to your CQC registration since the first wave you may not be aware that since April 2013 all new provider applications, or additions to current registrations, will need to be accompanied by a CQC countersigned DBS certificate.

DBS checks required for applications for, or changes to, registration can be made via the Post Office website: http://www.postoffice.co.uk/care-quality-commission.

Registrants need only apply for the DBS check online, print out the referral letter at the end of the online application process, and then go along to the nearest Post Office branch that provides this service with the referral letter and necessary identification documents.

Pre-Employment Checks

Where previously the employer would send the applicant to the KPCA to arrange the check, the employer will now need to obtain an application form from the DBS or an umbrella body, give the applicant the form to complete and return alongside the relevant identification documents, and then send it along to an umbrella body to process. A certificate will then be returned to the applicant who will in turn present it to the employer.

A plethora of umbrella organisa-

tions that can process DBS checks on behalf of practices can be found on the following website: https://dbs-ub-directory.homeoffice.gov.uk/.

Simply apply the relevant filters and you will be presented with a host of organisations that can assist with undertaking the necessary checks.

Applications to the National Performers List
Where previously the KPCA would carry out the DBS check for new applicants to the List, from the 1st April 2015 applicants will be expected to obtain the certificate themselves. This won't prove too difficult if an application to the List relates to a GP joining a practice as a partner or an employed member of the team as the practice they will be joining will be eligible to apply for a certificate. Locums, however, will still need to go through an employment agency to obtain an up to date certificate which some may find a nuisance. Fortunately, applicants need only apply for a certificate the once.

To avoid the complication of having to apply for a further certificate throughout your career we recommend that you sign up to the online update service. For £13 per year a copy of your DBS check will be kept up to date and online, and can be made available to future employers to check. The only catch is that you can only apply for this within 14 days of getting a new DBS check and to do so you will need the reference number from the top of the application form or certificate and apply online using the following website: https://secure.crbonline.gov.uk/crsc/apply?execution=e1s1

Posters in Waiting Rooms

Carlo Caruso, Deputy Clerk, Kent LMC

We have recently noticed that there have been some questions about posters in waiting rooms which appear to be arising from recommendations following CQC inspections. It has proven very difficult to identify what guidance this relates to and I can only assume that it relates to one of interpretation of a Health Building Note issued by the Department of Health around Infection Control in the Built Environment.

The Building Note focuses on the design and finish of ancillary areas, which in their design should "support effective prevention control" and "facilitate good cleaning". The nature of the infection prevention and control issues are determined by the specific use of the ancillary areas, who will have access to it, and the type of activity that will be carried out there.

In discussing waiting areas the guidance recognises the conflict between the aesthetic qualities and the prevention of contamination of the environment, and the ease of cleansing and disinfection, of these areas. It is important that, where blood or bodily fluid spillages may occur, the environment is such that facilitate effective cleaning.

Therefore, when considering whether a poster should be laminated or not, practices should first consider what risk there is of a poster in the waiting area becoming soiled by bodily fluids. Moreover, the requirements focus broadly upon the requirement that the environment is easy to clean and, therefore, one might argue that if a poster is not laminated, if soiled, it can easily be disposed of and replaced and is therefore of no greater infection risk than a laminated poster and so it would appear from the Department of Health's guidance that there is no specific risk associated with a poster not being laminated.

Kent Primary Care Agency Services (KPCA)

Liz Mears, Clerk

As many of you are aware, there has been a national procurement process for the Primary Care Support Services (PCSS) which is KPCA for us in Kent and Medway.

As outlined in the DBS article, there are some services that have been deemed nationally as 'out of scope'. NHS England are working closely with KPCA to bring into line the local processes with national 'in scope' services.

We have been very fortunate to have received an extensive and reliable service for many years from KPCA, and we hope very much that this will continue. There is reassurance from NHS England that any transition to new processes will be smooth and nothing will transfer without a thorough handover. Practices will be notified of any changes that may affect them in due course.

Care Certificate for HCA/APs

Lorraine Hicking-Woodison, Health Care Support Worker Adviser, Practice Nurse Adviser Team, NHS South East Commissioning Support Unit (SECSU)

In the wake of the Francis Report highlighting poor care in health and social care, the Cavendish Review was established to investigate what can be done to ensure that all people using services are treated with care and compassion by healthcare assistants (HCA) and support workers in the NHS and social care.

This Independent Review into Health Care Support Workers (HCSW) found that preparation of healthcare assistants and social care support workers for their roles within care settings was inconsistent. A certificate of fundamental care – now known as the Care Certificate – has been designed to meet the recommendations set out in the report of the Cavendish Review.

The Care Certificate consists of standards that have been developed for support workers to demonstrate that they have gained the knowledge, skills and attitudes needed to provide high quality and compassionate care and support. It covers fifteen topics common to all health and social care settings and once achieved it will be transferable between roles and employers.

From April 2015, employers will be expected to ensure that newly appointed support workers achieve the Care Certificate standards before working unsupervised. The certificate is a key component of induction, and quality assurance and certification will be the employers responsibility.

Meeting the criteria of the Care Certificate in Kent and Medway G.P. Practices

Please see the Codes and Standards that have been developed by the Practice Nurse Adviser team at Kent and Medway Commissioning Support Unit for HCA/APs working in G.P. Practices for guidance on how to meet the standards.

http://www.kentlmc.org/kentlmc/website10.nsf/0/CF38A82CA650AF0680257D2300360B8C?OpenDocument

And GP staff training e-learning platform:
http://kmgp.learningpool.com/login/index.php

Training Needs

The Knowledge and Skills in Primary Care (KaSPaC) course is the recommended induction programme for HCSWs working in Kent and Medway G.P. Practices. KaSPaC or a Qualifications and Credit Framework (QCF) level 3 in Health and Social care programmes are expected to meet


skillsforcare Skills for Health NHS Health Education England

The Care Certificate

Why is the Care Certificate being developed?

In the wake of the Francis Inquiry, and following the identification of serious challenges in some other health and social care settings in 2013, Camilla Cavendish was asked by the Secretary of State to review and make recommendations on: the recruitment, learning and development, management and support of healthcare assistants and social care support workers, ensuring that this workforce provides compassionate care.

The resulting report, The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings (July 2013) found that preparation of healthcare assistants and social care support workers for their roles within care settings was inconsistent and she recommended development of a Certificate of Fundamental Care – the 'Care Certificate'.

When is the Care Certificate being introduced?

It is planned that the Care Certificate will be introduced in March 2015. Initially, draft Care Certificate documents (available from the partner websites) are being piloted with employers between April and September 2014.

Who should do the Care Certificate?

Health Care Assistants, Assistant Practitioners, Care Support Workers and those giving support to clinical roles in the NHS where there is any direct contact with patients. Care Support Workers denotes Adult Social Care workers giving direct care in residential and nursing homes and hospices, home care workers and domiciliary care staff. These staff are referred to collectively as Healthcare Support Workers (HCSW)/ Adult Social Care Workers (ASCW). Other roles in health and social care such as caring volunteers, porters, cooks or drivers that have direct contact with patients and service users could also undertake all or some of the Care Certificate, but in order for the Care Certificate to be awarded the person must achieve success in all of the outcomes and assessment requirements.

What does the Care Certificate cover?

The Care Certificate is the start of the career journey for these staff groups and is only one element of the training and education that will make them ready to practice within their specific sector. The Care Certificate builds on the Common Induction Standards (CIS) and National Minimum Training Standards (NMTS) and sets out explicitly the learning outcomes, competences and standards of behaviour that must be expected of a HCSW/ASCW in both sectors, ensuring that such a

1

most of the training needs of the Care Certificate. (Safeguarding and Dementia training is available via eLearning). Both courses can be accessed via the GP staff training team at: kmgpstafftraining@nhs.net.

Health Education England (HEE) have developed a suite of materials that will be made freely available for employers to download and use to support them in implementing the Care Certificate.

For further information:
http://hee.nhs.uk/work-programmes/the-care-certificate/

Kent Local Medical Committee

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Noticeboard

Changes to the NHS Diabetic Eye Screening Programme (DESP) across Kent & Medway

Medical Imaging UK Ltd (MIUK) a national and well established independent company (already providing eye screening to 13 DESPs) have been appointed as the new service provider (www.medicalimaging.co.uk).

What MIUK as the new provider aims to offer
MIUK will be offering screening at GP surgeries, health centres, hospitals and selected high street optometry stores (Specsavers) at a time and date convenient to service users including extended opening hours and weekend appointments. The venue finder on our website will assist clinicians and patients in finding their most local outlet for screening. If practices feel the service can be more easily accessed from a specific location or from your practice, please contact us. If practices have any patients with specialist requirements, please contact our administration team on 01905 362770, Monday to Friday 8am-6pm and on Saturdays 8.30am to 2.30pm.

How you can help the service
Practices are asked to validate their lists of diabetic patients to the Failsafe Team on a 6 monthly basis and send new/updated patient information via www.miul.kentadmin@nhs.net. These lists will be extracted electronically in the near future using MIQUEST queries.

How we will keep you updated on outcomes from screening
Practices will be advised of the outcome of each screening (and each DNA) so this can be appended to the patients care record. Patients with sight threatening diabetic retinopathy will be directly referred to the hospital eye service by us. We will inform you of this outcome. If we see a patient who has a potentially sight threatening problem that is not related to diabetes, we will send you a referral request so the patient can be referred by their GP appropriately to the hospital.

Continuing to work with the Paula Carr Trust
We are delighted to announce that the staff at the Paula Carr Trust who have given you such good care are transferring to our organisation providing you with further reassurance and service continuity. MIUK will be working very closely with the Paula Carr Trust to carry on from where they left off.

Pamela Hebditch - Kent & Medway DESP Programme Manager
Paula Carr Diabetes Care Centre, William Harvey Hospital, Ashford, Kent (Tel: 01233 651843)

Kent & Medway NHS Social Care Partnership Trust

Kent and Medway NHS and Social Care Partnership Trust now has a cleaner and more engaging website. Developed in conjunction with service users, carers and our staff, the site gives visitors a clear pathway into services and opportunities available in the Trust.

You may be interested in our new Research and Innovations page which currently features our Open Dialogue pilot. Open Dialogue is a national project looking at the therapeutic relationship and the importance of dialogue to foster personal recovery and humanising psychiatry and mental health care. This approach originated in Finland in the 1980s, where it is now standard psychiatric care. KMPT is one of four Trusts now running pilot schemes and funding staff to undergo training. Some of those involved will be writing updates detailing their experience. You can find out more at www.kmpt.nhs.uk/research-and-development.

Further projects will be showcased here for you to keep up to date with Trust advancements and how you can become involved.

The website will continue to develop as we endeavour to make it as user friendly and as informative as we can. Please take a look and let us know your thoughts. Contact us on communications@kmpt.nhs.uk with your comments.